

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	County of Injury	Birthdate
Treating Physician		Physician's Specialty	
Diagnosis and Secondary Conditions			

SECTION 2 REQUEST FOR A SPECIFIC CATASTROPHIC REHABILITATION SUPPLIER

The Board will issue an Administrative Decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an Administrative Decision naming that supplier to work with this employee.

Name of requested Catastrophic Rehabilitation Supplier

Registration No.

SECTION 3 THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's Education Level :

Employee's Work History for the last 15 years, including physical requirements of each job (e.g. pounds lifted, hours standing / sitting / walking, etc.)

Dates/Job Title	Physical Requirements

Attach this form to a statement from this employee's authorized treating physician(s) indicating the physician(s)' opinion of the employee's work ability. This statement must be dated no more than one year prior to the certified mailing date of this form. This must be submitted even if the employee is receiving social security disability (SSDI) or supplemental security income (SSI) benefits.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

This section must be completed by the requesting party.

Signature	Address		
Company / Firm Name			
E-mail Address	City	State	Zip Code

EMPLOYEE	Last Name	First Name	M.I.	Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Address		
CLAIMS OFFICE	Name					
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
SITF	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
PROPOSED SUPPLIER	Name		Telephone Number	Address		
E-mail Address		Reg. No.		City	State	Zip Code

The Board will issue an Administrative Decision, whether or not an objection is received.

If there is an objection:

- (1) The objection must be filed on the WC-Rehab Objection form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
- (2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the Certificate of Service.
- (3) A Certificate of Service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the Certificate of Service.

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